Helping Ensure Accountability, Leadership, and Trust in Tribal Healthcare (HEALTTH) Act

Section-by-Section Summary

June 8, 2016

Section 1. Short title; table of contents
States that this Act may be cited as the "Helping Ensure Accountability and Trust in Tribal Healthcare (HEALTTH) Act of 2016;" list the bill's table of contents.

Sec. 2. Findings
Establishes the need for reform of the Indian Health Service (IHS) by listing several findings by Congress including a reaffirmation of the United States government's treaty responsibility to provide health care to American Indians and Alaska Natives and a description of the fundamental, systemic failures in the Great Plains Area of the IHS, which has resulted in patient suffering and death.

TITLE I – Expanding Authorities and Improving Access to Care

Sec. 101. Service hospital long-term contract pilot program
Provides authority to IHS to undertake a pilot project to test a "third way" health care delivery model, an alternative to full direct-service and full self-governance, with an emphasis on preparing tribes for self-governance. Under the pilot, three direct-service IHS hospitals will be fully contracted to a private sector health care company and a governance structure will be created and implemented, all in coordination with the tribe(s) served by the facility. The governance structure will be a hospital board modeled on private sector hospital boards. The boards will consist of IHS representatives, representatives of the tribe(s) served by the hospital, representatives of the contractor, as well as health and health administration experts to be chosen by the IHS and tribe(s) together. In order for a selected hospital to participate, the IHS must

obtain the permission of the tribe(s) served by the hospital. The tribe(s) may end the pilot at any time if they wish to enter into a self-governance contract.

Sec. 102. Expanded hiring authority for the Indian Health Service
Provides hiring authority to the IHS that is similar to that of the Department of Veterans Affairs (VA).

Sec. 103. Removal or demotion of employees
Streamlines the IHS' authority to fire or demote underperforming employees in a way that is similar to broadly-supported proposals for such processes in the VA.

Sec. 104. Improving timeliness of care
Requires the IHS to develop and implement standards to measure the timeliness of care at direct-service IHS facilities, then develop and implement a process by which these facilities report data collected under those standards.

TITLE II – Indian Health Service Recruitment and Workforce

Sec. 201. Exclusion from gross income for payments made under Indian health service loan repayment program
Amends the Internal Revenue Code to exclude from the definition of gross income payments made by the IHS student loan repayment program, effectively making these payments tax-free. This aligns the treatment of IHS student loan payments with the treatment of those made by the National Health Service Corps.

Sec. 202. Clarifying that certain degrees qualify individuals for eligibility in the Indian Health Service Loan Repayment Program
Explicitly includes health administration-related degrees in the list of those degrees eligible for participation in the IHS student loan repayment program. Allows IHS employees to utilize the program on a half-time basis.

Sec. 203. Cultural competency programs
Requires the IHS to develop and implement a cultural training program for each IHS Service Area to familiarize employees with the cultures of the Indian tribes they serve. Each Area's program must be developed in consultation with tribes. Training will be mandatory for certain IHS employees, locum tenens providers, and other contractors, and they will be tested annually. The provision applies to all contracts signed on or after the date of enactment.

Sec. 204. Relocation reimbursement
Amends the IHS' existing authority to provide relocation reimbursement for employees by allowing the agency to provide up to 75 percent of base pay for relocation expenses without prior approval from the Office of Personnel Management in the following circumstances: 1) the employee is relocating to a rural or medically underserved area, 2) the position has not been filled by a full-time non-contractor for over six months, or 3) the position is for hospital management or administration.

Sec. 205. Authority to waive Indian preference laws
Grants the IHS the authority (after obtaining Tribal consent) to waive Indian preference laws for positions at any IHS facility that has a vacancy rate of over 20 percent. Also grants the IHS authority to waive an individual's ability to apply under Indian preference for up to five years when the individual is a former IHS or tribal employee who was removed for conduct or performance issues.

Sec. 206. Streamlining licensed health professional volunteer credentialing process
Requires the IHS to centralize its licensed health professional volunteer credentialing procedures at the agency level rather than the facility level to reduce the paperwork burden on licensed health professionals who wish to volunteer at IHS direct-service facilities. Allows the IHS to consult with public and private sector associations in the development of this system. Those tribes who operate their own facilities under self-governance laws may choose to participate in the centralized system.

TITLE III – Purchased/Referred Care Program reforms

Sec. 301. Limitation on charges for certain purchased/referred care program services
Codifies the recent IHS rules that provide for the payment of Medicare-like rates for both hospital and non-hospital services obtained by IHS-eligible individuals outside the IHS system. Allows the Secretary, tribes, tribal organization, and urban Indian organizations discretion to negotiate above Medicare rates under certain circumstances. Requires the IHS to report to Congress within two years regarding access to care under the Purchased/Referred Care program, including recommendations for legislative action.

Sec. 302. Allocation of Purchased/Referred Care Program funds
Requires the IHS to develop and implement within three years a new Purchased/Referred Care allocation formula that accounts for a variety of factors. Allows for a three year transition period to the new system, during which the IHS will freeze 2016 base Purchased/Referred Care funding level for those facilities that have achieved Priority Level III- V for most services; facilities that have achieved Priority Levels I-II would receive the excess funding as determined by the IHS.

The transition is mandatory for direct-service IHS facilities, but those operated by a tribe, tribal organization, or urban Indian organization may choose to participate. Requires IHS to report to Congress on access to care and financial stability under the new formula.

Sec. 303. Purchased/Referred Care Program backlog
Requires the IHS to develop and implement a prioritization of unpaid balances to private medical providers under the Purchased/Referred Care program for each Area.

Sec. 304. Report on financial stability of Service hospitals and facilities
Requires the Government Accountability Office to report to Congress on issues related to the financial stability of IHS hospitals and facilities that have experienced sanction or threat of sanction by the Centers for Medicare and Medicaid Services, focusing on the effects of any revenues lost as a result of those CMS actions.